

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 1489</b>	<b>Date: April 11, 2008</b>
	<b>Change Request 5968</b>

**SUBJECT: Nursing Facility Services (Codes 99304 - 99318)**

**I. SUMMARY OF CHANGES:** This transmittal updates Chapter 12, §30.6.13 by noting that the typical/average time units for E/M visit codes in the Nursing Facility Services code family are reestablished and applicable. The American Medical Association Current Procedural Terminology Panel have reestablished these time units. Therefore, medically necessary prolonged services for E/M visits and medically necessary time-based visits for counseling and/or coordination of care for Nursing Facility Services may be billed with the appropriate prolonged services codes (99356 and 99357).

**NEW / REVISED MATERIAL**

**EFFECTIVE DATE: \*July 1, 2008**

**IMPLEMENTATION DATE: July 7, 2008**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	Chapter / Section / Subsection / Title
R	12/30/30.6.13/Nursing Facility Services (Codes 99304 - 99318)

**III. FUNDING:**

**SECTION A:** For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

**SECTION B:** For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

#### **IV. ATTACHMENTS:**

**Business Requirements**

**Manual Instruction**

*\*Unless otherwise specified, the effective date is the date of service.*

# Attachment - Business Requirements

Pub. 100-04	Transmittal: 1489	Date: April 11, 2008	Change Request: 5968
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**SUBJECT: Nursing Facility Services (Codes 99304 – 99318)**

**EFFECTIVE DATE:** July 1, 2008

**IMPLEMENTATION DATE:** July 7, 2008

## I. GENERAL INFORMATION

**A. Background:** This transmittal updates Chapter 12, §30.6.13 (F) by noting that the typical/average time units for E/M visit codes in the Nursing Facility Services code family are reestablished and applicable. The typical/average time units for evaluation and management (E/M) services in the Nursing Facility code family were removed by the American Medical Association Current Procedural Terminology (CPT) Panel effective for January 1, 2006. This action precluded billing of prolonged services for E/M visits in a skilled nursing facility or nursing facility until typical/average times were reestablished. Counseling and/or coordination of care was also precluded during this time because this service is time-based and typical/average time units were not available.

**B. Policy:** These typical/average time units have been reestablished beginning January 1, 2008, by the American Medical Association CPT. Therefore, medically necessary prolonged services for E/M visits in a skilled nursing facility or nursing facility (codes 99356 and 99357) may be billed with Nursing Facility Services (code range 99304 – 99306, 99307 – 99310 and 99318). Additionally, medically necessary E/M visits for counseling and/or coordination of care for Nursing Facility Services, that are time-based services, may be billed with the appropriate prolonged service codes (99356 and 99357).

## II. BUSINESS REQUIREMENTS TABLE

*Use "Shall" to denote a mandatory requirement*

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				OTH ER
		M A C	M A C				F I S S	M C S	V M S	C W F	
5968.1	Contractors shall instruct physicians and qualified nonphysician practitioners they may report medically necessary prolonged services (CPT codes 99356 and 99357) with the companion Nursing Facility Services in the code range (99304 – 99306, 99307 – 99310, and 99318).	X			X						
5968.1.1	Contractors shall pay for medically necessary prolonged	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I  M A C	C A R I E R	R H I  S S	Shared-System Maintainers				OTH ER
							F I S	M C S	V M S	C W F	
	services as identified in 5968.1										
5968.2	Contractors shall instruct physicians and qualified nonphysician practitioners they may report medically necessary prolonged services (CPT codes 99356 and 99357) with the companion Nursing Facility Services in the code range (99304 – 99306, 99307 – 99310, and 99318) for counseling and/or coordination of care services based on time.	X			X						
5968.2.1	Contractors shall pay for medically necessary prolonged services for counseling and/or coordination of care services as identified in 5968.2	X			X						

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I  M A C	C A R I E R	R H I  S S	Shared-System Maintainers				OTH ER
							F I S	M C S	V M S	C W F	
5968.3	<p>A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLNMattersArticles/">http://www.cms.hhs.gov/MLNMattersArticles/</a> shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>	X			X						

#### IV. SUPPORTING INFORMATION

**Section A: For any recommendations and supporting information associated with listed requirements, use the box below:**

*Use "Should" to denote a recommendation.*

<b>X-Ref Requirement Number</b>	<b>Recommendations or other supporting information:</b>
N/A	

**Section B: For all other recommendations and supporting information, use this space:**

American Medical Association Current Procedural Terminology 2008, pp.22 – 24, Nursing Facility Services code descriptions with the typical/average time units.

#### V. CONTACTS

**Pre-Implementation Contact(s):** Kit Scally (Cathleen.Scally@cms.hhs.gov)

**Post-Implementation Contact(s):** Appropriate Regional Office staff

#### VI. FUNDING

**Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**Section B: For *Medicare Administrative Contractors (MACs)*, use the following statement:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

### **30.6.13 - Nursing Facility Services (Codes 99304 - 99318)**

*(Rev.1489, Issued: 04-11-08, Effective: 07-01-08, Implementation: 07-07-08)*

#### **A. Visits to Perform the Initial Comprehensive Assessment and Annual Assessments**

The distinction made between the delegation of physician visits and tasks in a skilled nursing facility (SNF) and in a nursing facility (NF) is based on the Medicare Statute. Section 1819 (b) (6) (A) of the Social Security Act (the Act) governs SNFs while section 1919 (b) (6) (A) of the Act governs NFs. For further information refer to Medlearn Matters article number SE0418 at [www.cms.hhs.gov/medlearn/matters](http://www.cms.hhs.gov/medlearn/matters)

The initial visit in a SNF and NF must be performed by the physician except as otherwise permitted (42 CFR 483.40 (c) (4)). The initial visit is defined in S&C-04-08 (see [www.cms.hhs.gov/medlearn/matters](http://www.cms.hhs.gov/medlearn/matters)) as the initial comprehensive assessment visit during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the nursing facility resident. For Survey and Certification requirements, a visit must occur no later than 30 days after admission.

Further, per the Long Term Care regulations at 42 CFR 483.40 (c)(4) and (e) (2), the physician may not delegate a task that the physician must personally perform. Therefore, as stated in S&C-04-08 the physician may not delegate the initial visit in a SNF. This also applies to the NF with one exception.

The only exception, as to who performs the initial visit, relates to the NF setting. In the NF setting, a qualified NPP (i.e., a nurse practitioner (NP), physician assistant (PA), or a clinical nurse specialist (CNS), who is not employed by the facility, may perform the initial visit when the State law permits this. The evaluation and management (E/M) visit shall be within the State scope of practice and licensure requirements where the E/M visit is performed and the requirements for physician collaboration and physician supervision shall be met.

Under Medicare Part B payment policy, other medically necessary E/M visits may be performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit. A qualified NPP may perform medically necessary E/M visits prior to and after the initial visit if all the requirements for collaboration, general physician supervision, licensure and billing are met.

The CPT Nursing Facility Services codes shall be used with place of service (POS) 31 (SNF) if the patient is in a Part A SNF stay. They shall be used with POS 32 (nursing facility) if the patient does not have Part A SNF benefits or if the patient is in a NF or in a non-covered SNF stay (e.g., there was no preceding 3-day hospital stay). The CPT Nursing Facility code definition also includes POS 54 (Intermediate Care Facility/Mentally Retarded) and POS 56 (Psychiatric Residential Treatment Center). For further guidance on POS codes and associated CPT codes refer to §30.6.14.

Effective January 1, 2006, the Initial Nursing Facility Care codes 99301– 99303 are deleted.

Beginning January 1, 2006, the new CPT codes, Initial Nursing Facility Care, per day, (99304 – 99306) shall be used to report the initial visit. Only a physician may report

these codes for an initial visit performed in a SNF or NF (with the exception of the qualified NPP in the NF setting who is not employed by the facility and when State law permits, as explained above).

A readmission to a SNF or NF shall have the same payment policy requirements as an initial admission in both the SNF and NF settings.

A physician who is employed by the SNF/NF may perform the E/M visits and bill independently to Medicare Part B for payment. An NPP who is employed by the SNF or NF may perform and bill Medicare Part B directly for those services where it is permitted as discussed above. The employer of the PA shall always report the visits performed by the PA. A physician, NP or CNS has the option to bill Medicare directly or to reassign payment for his/her professional service to the facility.

As with all E/M visits for Medicare Part B payment policy, the E/M documentation guidelines apply.

### **B. Visits to Comply With Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF**

Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial visit by the physician, payment shall be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.

Effective January 1, 2006, the Subsequent Nursing Facility Care, per day, codes 99311–99313 are deleted.

Beginning January 1, 2006, the new CPT codes, Subsequent Nursing Facility Care, per day, (99307 – 99310) shall be used to report federally mandated physician E/M visits and medically necessary E/M visits.

Carriers shall not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service. The Nursing Facility Services codes represent a “per day” service.

The federally mandated E/M visit may serve also as a medically necessary E/M visit if the situation arises (i.e., the patient has health problems that need attention on the day the scheduled mandated physician E/M visit occurs). The physician/qualified NPP shall bill only one E/M visit.

Beginning January 1, 2006, the new CPT code, Other Nursing Facility Service (99318), may be used to report an annual nursing facility assessment visit on the required schedule of visits on an annual basis. For Medicare Part B payment policy, an annual nursing facility assessment visit code may substitute as meeting one of the federally mandated physician visits if the code requirements for CPT code 99318 are fully met and in lieu of reporting a Subsequent Nursing Facility Care, per day, service (codes 99307 – 99310). It shall not be performed in addition to the required number of federally mandated physician visits. The new CPT annual assessment code does not represent a new benefit service for Medicare Part B physician services.

Qualified NPPs, whether employed or not by the SNF, may perform alternating federally mandated physician visits, at the option of the physician, after the initial visit by the physician in a SNF.

Qualified NPPs in the NF setting, who are not employed by the NF, may perform federally mandated physician visits, at the option of the State, after the initial visit by the physician.

Medicare Part B payment policy does not pay for additional E/M visits that may be required by State law for a facility admission or for other additional visits to satisfy facility or other administrative purposes. E/M visits, prior to and after the initial physician visit, that are reasonable and medically necessary to meet the medical needs of the individual patient (unrelated to any State requirement or administrative purpose) are payable under Medicare Part B.

### **C. Visits by Qualified Nonphysician Practitioners**

All E/M visits shall be within the State scope of practice and licensure requirements where the visit is performed and all the requirements for physician collaboration and physician supervision shall be met when performed and reported by qualified NPPs. General physician supervision and employer billing requirements shall be met for PA services in addition to the PA meeting the State scope of practice and licensure requirements where the E/M visit is performed.

#### **Medically Necessary Visits**

Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial visit in both the SNF and NF. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B. CPT codes, Subsequent Nursing Facility Care, per day (99307 - 99310), shall be reported for these E/M visits even if the visits are provided prior to the initial visit by the physician.

#### **SNF Setting--Place of Service Code 31**

Following the initial visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.

#### **NF Setting--Place of Service Code 32**

Per the regulations at [42 CFR 483.40 \(f\)](#), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.

## **D Medically Complex Care**

Payment is made for E/M visits to patients in a SNF who are receiving services for medically complex care upon discharge from an acute care facility when the visits are reasonable and medically necessary and documented in the medical record. Physicians and qualified NPPs shall report E/M visits using the Subsequent Nursing Facility Care, per day (codes 99307 - 99310) for these E/M visits even if the visits are provided prior to the initial visit by the physician.

## **E Incident to Services**

Where a physician establishes an office in a SNF/NF, the “incident to” services and requirements are confined to this discrete part of the facility designated as his/her office. “Incident to” E/M visits, provided in a facility setting, are not payable under the Physician Fee Schedule for Medicare Part B. Thus, visits performed outside the designated “office” area in the SNF/NF would be subject to the coverage and payment rules applicable to SNF/NF setting and shall not be reported using the CPT codes for office or other outpatient visits or use place of service code 11.

## **F Use of the Prolonged Services Codes and Other Time-Related Services**

*Beginning January 1, 2008, typical/average time units for E/M visits in the SNF/NF settings are reestablished. Medically necessary prolonged services for E/M visits (codes 99356 and 99357) in a SNF or NF may be billed with the Nursing Facility Services in the code ranges (99304 – 99306, 99307 – 99310 and 99318).*

### **Counseling and Coordination of Care Visits**

*With the reestablishment of typical/average time units, medically necessary E/M visits for counseling and coordination of care, for Nursing Facility Services in the code ranges (99304 – 99306, 99307 – 99310 and 99318) that are time-based services, may be billed with the appropriate prolonged services codes (99356 and 99357).*

## **G Gang Visits**

The complexity level of an E/M visit and the CPT code billed must be a covered and medically necessary visit for each patient (refer to [§§1862 \(a\)\(1\)\(A\)](#) of the Act). Claims for an unreasonable number of daily E/M visits by the same physician to multiple patients at a facility within a 24-hour period may result in medical review to determine medical necessity for the visits. The E/M visit (Nursing Facility Services) represents a “per day” service per patient as defined by the CPT code. The medical record must be personally documented by the physician or qualified NPP who performed the E/M visit and the documentation shall support the specific level of E/M visit to each individual patient.

## **H Split/Shared E/M Visit**

A split/shared E/M visit cannot be reported in the SNF/NF setting. A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same

employer. The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non facility clinic visits, and prolonged visits associated with these E/M visit codes). The split/shared E/M policy does not apply to consultation services, critical care services or procedures.

### **I SNF/NF Discharge Day Management Service**

Medicare Part B payment policy requires a face-to-face visit with the patient provided by the physician or the qualified NPP to meet the SNF/NF discharge day management service as defined by the CPT code. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified NPP even if the patient is discharged from the facility on a different calendar date. The CPT codes 99315 – 99316 shall be reported for this visit. The Discharge Day Management Service may be reported using CPT code 99315 or 99316, depending on the code requirement, for a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement.